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WILLIAM T FUJIOKA
Chief Executive Officer



November 12, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

**FUNDING FOR FRAUD INVESTIGATIONS AND PROGRAM INTEGRITY EFFORTS RELATED TO THE IN-HOME SUPPORTIVE SERVICES PROGRAM PURSUANT TO THE CALIFORNIA STATE BUDGET ACT OF 2009 (AGENDA ITEM NO. 41 FOR NOVEMBER 17, 2009)**

On October 6, 2009, your Board adopted Supervisors Knabe's and Antonovich's motion directing the Chief Executive Officer (CEO) and the Director of Public Social Services (DPSS) with assistance from the District Attorney (DA), to determine funding sources for the $1.53 million required as the County's share of funding to draw down State and federal funding to combat In-Home Supportive Services (IHSS) fraud, and to develop and submit for Board approval the County's IHSS anti-fraud plan, as required by the State. Attached for Board approval and the Chairman's signature is the Los Angeles County Plan.

## BACKGROUND

IHSS provides personal care and domestic services to persons who are aged, blind or disabled and live in their own homes, and who otherwise might be placed in an out-of-home care facility, but can safely remain in their own home if IHSS services are received. The program is administered by each County with oversight by the California Department of Social Services (CDSS). In Los Angeles, the program includes 185,000 IHSS consumers and over 150,000 providers of those services.

Since April 2004, the California Department of Health Care Services has been solely responsible for investigation of fraud in the IHSS program. On July 28, 2009, the Governor signed AB X4 19, which amended Section 12305.82 of the Welfare and Institutions Code to provide Counties with the authority to investigate fraud in IHSS, and

appropriated $10 million of State funds for the purpose of fraud prevention efforts related to IHSS. Counties opting to participate in this opportunity must submit a plan, with a corresponding budget, by December 1, 2009.

On September 25, 2009, CDSS issued a letter to all County Board of Supervisors advising them of the availability of funds for the purpose of fraud prevention, detection, referral, investigation, and additional program integrity efforts related to the IHSS program. DPSS and the DA partnered with the State in developing a robust and comprehensive plan.

## FISCAL IMPACT

The total available statewide funds for this effort, when combined with matching federal and required County matching funds, are $26.4 million. Los Angeles County's allocation is $9.460 million including $1.533 million in County matching funds. DPSS and the DA will identify funding in their existing budgets to provide the required match. DPSS will fund $1.308 million and the DA will fund $0.225 million. Funding is expected to be renewed annually by the State providing counties have demonstrated that anticipated outcomes have been achieved.

The attached plan prescribes the specific content requirements and components as outlined by the State. The proposals inherent in the plan are both broad in scope and yet narrow in focus, as targeted strategies, anchored on prior best practices and program integrity imperatives, are strengthened and expanded through the funding opportunities created by the 2009 State Budget Act.

I believe this plan will serve as a model throughout the State and will augment current anti-fraud initiatives already successfully implemented in DPSS.

WTF:JW
JAB:cvb

Attachments

c: District Attorney
Acting County Counsel
Executive Officer, Board of Supervisors
Director, Public Social Services

# LOS ANGELES COUNTY

DEPARTMENT OF PUBLIC SOCIAL SERVICES AND
OFFICE OF THE DISTRICT ATTORNEY

Los Angeles County is requesting participation in the Enhanced In-Home Supportive Services Anti-Fraud Program. Our plan prescribes to the specific content requirements as outlined in the September 25, 2009 California Department of Social Services letter to all County Board of Supervisors.

Board of Supervisor Approval

Approved on the _____ day of November 2009, by the Los Angeles County Board of Supervisors.

Supervisor Don Knabe, Chairman of the Board

Signature: _____

Name of County District Attorney Representative:

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# LOS ANGELES COUNTY IHSS ANTI-FRAUD PLAN

## Executive Summary

The Department of Public Social Services (DPSS) and the Office of the District Attorney (DA) partnered with the California Department of Health Care Services (CDHCS) to include these initiatives in Los Angeles County's In-Home Supportive Services (IHSS) Fraud Prevention Plan. The Plan prescribes to the specific content requirements and components outlined in the September 25, 2009 California Department of Social Services letter to all County Board of Supervisors.

The proposals are both broad in scope and yet narrow in focus, as targeted strategies anchored on prior best practices and program integrity imperatives are strengthened and expanded through the funding opportunities created by the 2009 State Budget Act. The identified additional staff costs include salaries, benefits and indirect costs.

| PROPOSED INITIATIVE | BRIEF EXPLANATION OF THE PROCESS |
|---|---|
| Create a Front End Verification Review (*FEVR*) Unit of Social Workers (SWs) to complete front end verification of applicant/customers who are referred by their SW due to questionable information. | Modeled after our current Early Fraud Detection process used in CalWORKs and Food Stamps, this provides further scrutiny of IHSS consumers and providers who exhibit evidence or characteristics of potential program violation. The process will prevent issuance of incorrect benefits and require more in-depth verification and assessment than is usually needed for eligibility determination.<br>Staffing: 21 – SWs, 3 - Supervising SWs<br>Cost: $3,746,000 |
| Taskforce Approach | Taskforce approach maintains qualified investigative staff and promotes interagency cooperation to concurrently investigate the myriad of fraud related offenses committed in public aid programs. CalWORKs, Food Stamps and Child Care fraud have been the primary focus of these criminal investigations. However, DPSS, DA and CDHCS investigators have discovered fraud activities related to the same suspects in the areas of Medi-Cal, Section 8 Housing, and IHSS. The current Inter-Agency Taskforce would expand to include IHSS investigators.<br><br>Staffing: 7 - DPSS Investigators (WFI)<br>1 - DPSS Supervising Investigator (SWFI)<br>6 - Senior DA Investigators (DAI)<br>1 - Supervising DA Investigator<br><br>DPSS Staff Cost: $1,128,000<br>DA Staff Cost: $1,383,000<br>TOTAL COST: $2,511,000 |
| Explore Use of Data Mining for IHSS Fraud Detection and Prevention. | DPSS is currently exploring the use of Data Mining in Child Care fraud prevention and will explore the feasibility of utilizing this technology in IHSS.<br>No cost in FY 09-10.<br>Implement in FY 10-11 based on available funding. |

# LOS ANGELES COUNTY IHSS ANTI-FRAUD PLAN

## Executive Summary

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| DPSS to work with L.A. County Registrar-Recorder to receive Death Notification prior to forwarding to State. | DPSS will explore the feasibility of receiving Death Match information from the L.A. County Registrar-Recorder prior to or at the same time Los Angeles information is forwarded to CDHCS.<br>No cost in FY 09-10.<br>Implement in FY 10-11 based on available funding. |
| CDHCS to station an IHSS Fraud Investigator in each Regional IHSS Office. | This is an ongoing initiative between DPSS and CDHCS that will continue as part of our IHSS fraud prevention plan.<br>Staffing: Provided by CDHCS<br>Cost: Minimal |
| DA to provide a Deputy DA who will guide and provide training to DA/ CDHCS/WFP&I Investigators on investigating and successfully prosecuting IHSS fraud. | DPSS' current practice of working directly with the DA prosecutors on CalWORKS and Food Stamps fraud has proven very successful. The Deputy DA would provide training and work with investigative staff on IHSS cases sent forward for prosecution.<br>Staffing: I - Deputy DA<br>Cost: $253,000 |
| Project Manager for IHSS Anti-Fraud Initiatives | Hire a consultant to explore IHSS anti-fraud initiatives recently signed into law (see attached) to determine implementation requirements and associated costs.<br>Cost: $55,000 (Retiree) |
| Front End Analysis of Referrals (Triage) | Additional SW assigned full-time to triage incoming fraud referrals for accuracy and provide training and feedback.<br>Staffing: 1 - SW<br>Cost: $154,000 |
| Enhanced Quality Assurance/<br>Quality Improvement Program – (QA/QI) | Currently, Los Angeles County DPSS conducts quarterly QA/QI monitoring reviews on IHSS cases selected at random from all IHSS district offices and all Social Workers involved in the assessment process. With current available resources, sampling of the large IHSS caseload is limited. An additional unit of staff performing QA/QI will enable the review of an expanded sample of IHSS cases each quarter and additional focused reviews, and data match reviews in support of program integrity and fraud detection.<br>Staffing: 5 - SWs, 1 - Supervising SW<br>Cost: $941,000 |
| Fraud Prevention Tools for IHSS Line Staff | Develop training material on fraud prevention techniques and best practices.<br>Cost: Minimal |

# LOS ANGELES COUNTY IHSS ANTI-FRAUD PLAN

## Executive Summary

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| Develop automated system to track all IHSS investigations in Los Angeles County. | This is a plan requirement. CDHCS has a statewide tracking system that we will explore.<br>Staffing: 1 - Principal Application Developer (PAD)<br>1 - Senior Principal Application Developer<br>2 - Information Systems Analyst II (ISA II)<br>1 - IT Tech Support Analyst II (TSA II)<br>1 - ITSSMA Consultant<br><br>Staffing Cost: $ 900,000<br>(Includes $277,000 for ITSSMA Consultant)<br>IT Cost: $ 900,000<br>TOTAL COST: $ 1,800,000 |
| **TOTAL COST: $9,460,000** | TOTAL STAFF 54 Positions<br>Social Workers: 27 - SWs, 4 – SSWs<br>DPSS Investigators: 7 - WFIs, 1 - SWFI,<br>DA Investigators: 6 - Sr. DAIs, 1 - Supr DAI, 1 - Deputy DA<br>DPSS IT Staff: 1 - PAD, 1 - Senior PAD, 2 - ISAs,<br>1 - TSA, 1 - Consultant, 1 – Retiree |

# LOS ANGELES COUNTY IN-HOME SUPPORTIVE SERVICES
# ANTI-FRAUD PLAN

The following represents a comprehensive and collaborative Anti-Fraud Plan (Plan) aimed at the prevention, detection, referral and investigation of fraud in the In-Home Supportive Services (IHSS) program. The Plan has been developed in partnership with our Los Angeles County District Attorney's office (DA) as well as the California Department of Health Care Services (CDHCS) Investigations Section and the California Department of Social Services (CDSS).

The Plan prescribes to the specific content requirements and components as outlined in your letter of September 25, 2009 to all County Board of Supervisors. The proposals inherent in the Plan are both broad in its scope and yet narrow in its focus, as targeted strategies, anchored on prior best practices and program integrity imperatives, are strengthened and expanded through the funding opportunities created by the 2009 State Budget Act. Los Angeles County is prepared and committed to commence work on all new initiatives described in this Plan within 60 days of receipt of funding.

## I. LOS ANGELES COUNTY'S CURRENT AND PROPOSED ANTI-FRAUD ACTIVITIES RELATED TO THE IHSS PROGRAM

### A. Current Activities

The 2007-2008 Civil Grand Jury Report made several recommendations to improve the integrity of the IHSS Program. In response, Los Angeles County Department of Public Social Services (DPSS) launched the first Statewide IHSS Fraud Prevention Roundtable in August, 2008. Officials from the DA, the CDHCS Investigations Section, CDSS, the Social Security Administration (SSA) and DPSS participated in the discussion and made recommendations on strategies to mitigate fraud in IHSS and address any pertinent changes in State Regulations.

The IHSS Fraud Prevention Roundtable (the first of its kind in the State) produced positive outcomes. As a result of the many ideas from this workgroup, DPSS implemented the following activities:

- Centralized "Advance Pay" Cases;
- Centralized in each IHSS Region DPSS employee/provider cases;
- Developed a mechanism to share results of IHSS fraud referrals with staff;
- Restricted access to data entry/terminal operators based on job functions; and
- Strengthened monthly and quarterly report reviews which indicate discrepancies and suspicious fraud activities and overpayments.

***Social Worker (SW) Training***

IHSS SWs, Managers and Quality Assurance staff received a one-day training course presented collaboratively by the DPSS Training Academy, CDHCS and IHSS Program staff. This training will be provided annually to IHSS Social Workers and as needed to newly hired Social Workers. Beginning July 13, 2009 through August 6, 2009, over 1,000 staff were trained in the following areas:

- Fraud Awareness and Prevention Strategies;
- How to Identify Fraud;
- The IHSS Fraud Referral process, including the IHSS Fraud Checklist as a Tool;
- Identify Potential IHSS Fraud Indicators;
- Recognize External and Internal Fraud;
- Document Fraud Allegations clearly on the Medi-Cal Complaint Form (MC 609-IHSS);
- The Court process, Subpoena and Testimony; and
- Restitution process.

***Data Exchanges***

Currently, IHSS data goes through data exchanges on the Medi-Cal Eligibility Data System (MEDS) and Case Management, Information and Payrolling System (CMIPS) Statewide computer systems. MEDS and CMIPS data is exchanged with other automated databases maintained by federal, State and other agencies. Data is exchanged to verify demographic data, income, eligibility data, and eligibility status. These data exchanges serve to primarily help SWs verify income and eligibility factors and help to avoid errors in issuing benefits.

Specialized staff also review monthly and quarterly reports which indicate discrepancies and suspicious activities, such as, Recipient/Provider Death Match, Monthly Exceptions Report, SSI/SSP Terminations Report, Provider 300+ Paid Hours Report, No Timesheet Activity for 60 Days Report, Out of State Warrants Report, WeTip complaints and other federal, State, and County Agency communications reports. Unresolved cases are forwarded to CDHCS as a fraud referral.

B. Proposed Activities

DPSS and the DA partnered with CDHCS to develop Los Angeles County's IHSS Fraud Prevention Plan and secure additional funding to enhance the integrity of the IHSS Program. Following is a description of additional initiatives which will enhance our current IHSS fraud prevention efforts.

### *Front End Verification Review (FEVR)*

Los Angeles County DPSS will develop and implement a Front End Verification Review process in the IHSS program, and will hire additional SWs needed to staff the program.

The Program, modeled after our very successful Early Fraud Detection Program in the CalWORKs and Food Stamp Program, will reduce potential overpayments, as well as the workload associated with them. Detecting and preventing fraud early in the application process is an important and well proven strategy in mitigating fraud.

This initiative provides further scrutiny of IHSS consumers and providers who exhibit evidence or characteristics of potential program violation. It will require more in-depth verification and assessment than is usually needed for eligibility determination.

DPSS in collaboration with the DA and CDHCS will develop an Error Prone Profile (EPP) for IHSS. An EPP is a list of characteristics that are common in error prone cases (Red Flags). The EPP will be reviewed and updated periodically to incorporate additional Red Flags that are relevant and cost effective. SWs will use the EPP to determine if a referral to the FEVR unit is appropriate.

A FEVR Unit, consisting of experienced SWs will be housed in each IHSS office location. Case-carrying SWs who encounter verification or information which is not consistent with the case record will make a referral to FEVR staff.

Referrals accepted by the FEVR SW will result in an unannounced home visit. The FEVR SW may conduct a new assessment of the IHSS consumer's eligibility or need for services and will make a fraud referral to CDHCS when the information or documents in question cannot be resolved or verified.

The following are some "high risk" or relevant characteristics for IHSS that SWs will use to determine if a FEVR interview is required:

- Information provided by either the IHSS consumer or provider is contradictory, incomplete or unclear;
- Fraud committed or alleged previously by an IHSS consumer or provider; and
- The requested services or approved activities are questionable and there is a close financial or family relationship between the consumer and the provider.

### *IHSS Fraud Prevention Taskforce*

DPSS will implement an IHSS Fraud Prevention Taskforce based on its successful Stage 1 Child Care Fraud Prevention Taskforce (created in 2004) to

address issues related to the identification and prevention of fraud in the Child Care Program. This Taskforce, hosted by DPSS' Welfare Fraud Prevention and Investigation (WFP&I) Section, meets quarterly and includes staff from the Child Care Alliance, Alternate Payment Providers, Resource and Referral Agencies (APPs/R&Rs), the DA, as well as staff from DPSS' Child Care Program Section and other sections with activities related to the Stage 1 Child Care Program.

The IHSS Fraud Prevention Taskforce will include staff from CDHCS, CDSS, DA, as well as staff from DPSS' WFP&I, IHSS Line and Program sections and other sections within the department.

***Data Mining***

Following a very successful pilot, Los Angeles County will implement Data Mining for the investigation of fraud in the Stage 1 Child Care Program in early 2010. The pilot objective was to demonstrate that Data Mining and advanced predictive analytics can significantly improve the current fraud detection process. Specifically, the County was seeking to focus on the following:

- Pre-emptive referrals (in addition to APP referrals) using historically known fraud patterns;
- Earlier detection of potential fraud;
- Improve the quality of referrals; and
- Facilitate the investigation of collusive fraud rings through network analysis.

To achieve this objective, the pilot project used historical data to validate solutions which can then be used effectively in a predictive manner. In total, seven solution components were confirmed after extensive collaboration with the CEO, DPSS, and WFP&I staff, after which three were chosen for development in the pilot project.

Once Data Mining is fully implemented in the Stage 1 Child Care Program, the County proposes to expand its use to identify fraud in the IHSS Program.

***Death Match***

Currently, staff review data exchange information on a California Department of Social Services (CDSS) Quarterly Death Match report identifying Medi-Cal recipients reported as deceased to determine if an overpayment has occurred. However, the data is several months old and only available in hard copy. In order to identify overpayments more timely, DPSS will explore the feasibility of receiving the data directly from the Los Angeles County Registrar-Recorder or Department of Public Health.

## II. COLLABORATION AND PARTNERSHIP WITH THE DISTRICT ATTORNEY RELATED TO THE IHSS PROGRAM

Los Angeles County DPSS has enjoyed a longstanding and successful collaboration with the DA and the Department of Probation in the prevention, investigation, prosecution and monitoring of individuals committing welfare fraud.

DPSS currently maintains and funds a Memorandum of Understanding (MOU) with the DA for Recipient Welfare Fraud Investigation, Internal Affairs Investigation, and prosecution of CalWORKs and Food Stamp fraud at a yearly cost of $9,403,000. This MOU has resulted in a very successful partnership in combating welfare fraud in the CalWORKs and Food Stamp Program. DPSS also has funds and maintains a MOU with the Probation Department for the Supervision of Persons convicted of Welfare Fraud at a cost of $850,000.

In May 2009, the DA's Recipient Welfare Fraud Investigation Unit Section, in collaboration with WFP&I, implemented a Public Assistance Crime Enforcement (PACE) Taskforce. The purpose of PACE is to maintain qualified investigative staff and promote interagency cooperation to concurrently investigate the myriad of fraud related offenses committed against a variety of public agencies.

CalWORKs, Food Stamps and Child Care Fraud have been the primary focus of these criminal investigations; however, WFP&I, DA and CDHCS Investigators have discovered fraud activities related to the same suspects in the areas of Medi-Cal, Section 8 Housing, and IHSS.

Investigators assigned to PACE currently conduct joint field operations on their respective cases. Having Investigators from the various agencies all located in the same facility builds upon ongoing collaboration and partnership to formally investigate fraud in all programs, including IHSS. This taskforce approach ensures team cohesiveness, accountability and unified tracking methodology to aid in the determination of program outcomes. DPSS' current practice of working directly with DA prosecutors on CWs/FS fraud has proven very successful. As part of this plan, a Deputy DA will provide training and work with investigative staff on IHSS cases sent forward for prosecution.

## III. COUNTY COLLABORATION AND PARTNERSHIPS WITH CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (CDHCS) AND THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CDSS) RELATED TO THE IHSS PROGRAM

DPSS and the DA in Los Angeles will continue to collaborate extensively with its partners in CDHCS and CDSS to ensure program integrity efforts. As stated earlier, Los Angeles County launched the first Statewide IHSS Fraud Prevention Roundtable in August 2008 with participation from CDHCS and CDSS. Many ideas from this workgroup have already been implemented in Los Angeles and we are committed to continue working closely with CDSS' Adult Programs Branch and Fraud Bureau, as well as with CDHCS' Investigation Section in the implementation of this plan.

Expanding the PACE Team Concept

In August 2009, investigative staff from CDHCS joined the PACE Team, specifically to provide an investigative source for IHSS and Medi-Cal fraud. Future plans are being developed to add the following agencies to the PACE Team: Social Security Administration, Department of Motor Vehicles, Internal Revenue Service, and City, County, and Federal Housing Authority (Section 8.) In addition, we are expanding PACE by adding an additional unit of Investigators from both WFP&I and the DA.

The CDHCS is working with DPSS to house one of their investigators in each of our IHSS Regions. This is an ongoing initiative between DPSS and CDHCS that will continue as part of our IHSS fraud prevention plan. Staffing will be provided by CDHCS.

## IV. DESCRIPTION OF HOW THE COUNTY WILL INTEGRATE OTHER PROGRAM INTEGRITY EFFORTS

The Budget for Fiscal Year 2009-10 signed by the Governor in July 2009, includes new regulations for IHSS fraud prevention and references strong anti-fraud initiatives to be enforced by counties as part of the IHSS fraud detection and prevention effort. In an effort to comply with the new State mandate, Los Angeles County has opted to explore the feasibility of hiring a consultant (Retiree) to ensure the timely implementation of the following required Program Integrity initiatives:

| Anti-Fraud Initiatives | Effective Date |
|---|---|
| New Provider Orientation<br>All prospective providers must complete orientation at time of enrollment.<br>(AbX4 19 Sec 3) | November 1, 2009 |
| Provider Enrollment Form<br>County staff must view original documents and see provider in person.<br>(ABX4 4, Sec 27) | November 1, 2009 |
| New Provider Background Check (Non-Registry)<br>Requires county to background check new providers not listed on a registry.<br>(ABX4 19 Sec 11) | November 1, 2009 |
| Current Provider Orientation<br>All current providers must receive orientation information and submit a signed agreement.<br>(ABX4 19 Sec 3) | Between November 1, 2009 and June 30, 2010 |

| Anti-Fraud Initiatives | Effective Date |
|---|---|
| Current Provider Background Check (Non-Registry)<br>Requires new providers to background check current providers not listed on a registry.<br>(ABX4 19 Sec 11) | July 1, 2010 |
| Notification of Suspect Fraud<br>Requires county to notify CDSS and DHCS if it concludes that there is reliable evidence that a provider or recipient has engaged in fraud.<br>(ABX4 19 Sec 9). | Effective the date the legislation takes effect. |
| Provider Address<br>States that a provider enrollment form must use a physical address and that checks cannot be mailed to a Postal Office Box unless the county approves a request from the provider.<br>(ABX4 19 Sec 10) | Effective the date the legislation takes effect. |
| New Provider Background Check (Registry)<br>Requires new providers to submit a background check to be on the registry. (ABX4 19 Sec 5) | Effective the date the legislation takes effect. |
| Targeted Mailers<br>CDSS shall consult with County Welfare Departments (CWDs) and stakeholders to develop protocols for the implementation of targeted mailings.<br>(ABX4 19 Sec 6) | Effective the date legislation takes effect.<br>No due date for protocols. |
| Home Visits<br>Adds to county QA functions that monitoring "may include" a home visit to verify receipt of services, and requires CDSS to develop protocols for the visits in consultation with CWDs.<br>(ABX4 19 Sec 7) | Effective the date the legislation takes effect.<br>No due date for protocols. |

## V. IHSS FRAUD REFERRALS/OUTCOMES

Effective April 2005, SB 1104 implemented new policies that enhanced detection and prevention of IHSS fraud. Welfare and Institution Code (WIC) Section 12305.82 established the authority and process for preventing, detecting, and investigating fraud in the IHSS Program. The Statute requires all suspected IHSS fraud to be referred to CDHCS for investigation. It also requires CDSS, CDHCS, and county Quality Assurance (QA) staff to work collectively to:

- Detect and prevent IHSS fraud based on applicable laws/regulation which include due process requirements;
- Take appropriate administrative action; and
- Refer suspected criminal offenses to law enforcement agencies.

Current IHSS Fraud Referral Procedures

CDHCS has the authority to pursue in a civil or criminal action, any person who receives funds or benefits to which he/she is not entitled. CDHCS is required to take all reasonable steps necessary to recoup or recover from a consumer and/or provider any overpayments made for IHSS services.

Currently, the IHSS Fraud Referral process is centralized in L.A. County. SWs from the various IHSS offices forward referrals to DPSS Headquarters for review and triage, prior to forwarding to CDHCS for investigation. This process, developed in collaboration with CDHCS, has streamlined the referral process, strengthened the accompanying documentation and reduced the number of negative referrals.

- IHSS Fraud Liaisons cooperate with CDHCS Fraud Investigators on inquiries, as needed, and provide any additional requested documents;
- Referrals are received, reviewed and prioritized by a CDHCS Supervising Fraud Investigator;
- Priority is determined based on a high propensity that the investigation will result in fraud findings and the likelihood of the investigation resulting in a criminal filing;
- Consideration is also given to the complexity of the cases; and
- CDHCS resolves most outstanding overpayments. However, if the overpayment is over $2,000 and the actions of the suspect justifies criminal charges be filed, the case is referred to the DA's Office.

Expanded Triage Approach

The triage approach has proven successful in reducing the number of unsubstantiated referrals and allows Investigators to concentrate on cases with a high probability of fraud. As part of this plan, we will add an additional SW to this function in order to further expedite the referral process to CDHCS.

Internal fraud is handled by the Internal Affairs Unit at Human Resources Division. This type of fraud is reported to the Office of County Investigations–Employee Fraud Hotline.

Fraud Referrals

As part of this plan, we will continue to work closely with CDHCS. Referrals will be handled as follows:

- Suspected fraud involving only the IHSS consumer and/or provider will be referred to CDHCS; and
- Suspected fraud on a case that involves multiple programs, i.e., CW/FS and IHSS, will be referred to the PACE Team.

DPSS, the DA and CDHCS staff will work together to ensure that only one investigation is conducted on referrals or allegations received by more than one agency.

Fraud Referral Process

A fraud investigation is an in-depth analysis that may involve a review of an entire case file as well as an examination of the particular elements that caused the review. The investigation is directed toward determining the accuracy of fraud allegations and the intent to commit fraud. The investigation may lead to prosecution.

The decision to refer the case to the DA Investigation Unit or the CDHCS Investigation Unit is the responsibility of DPSS.

The Investigator will use the information provided by the investigative report to help make the decision to refer for prosecution. Referral to the DA for prosecution consideration must meet the following criteria:

- The misrepresentation or concealment was done knowingly and deliberately;

- The purpose of the misrepresentation or concealment was to get IHSS funding to which the person was not entitled; and

- Had the facts been known to the agency, the IHSS funding would have been denied, discontinued, or reduced.

Appeal Process

Consumers who believe that an agency decision regarding any component of the IHSS Program is incorrect may request a fair hearing through the State Hearings and Appeals Division within 90 days from the date of the Notice of Action.

Confidentiality and Routine Disclosure

Both DPSS and the DA shall adhere to CDHCS confidentiality policies. Information about the consumer, provider, or reasons for the investigation shall not be divulged. IHSS consumer records and data are confidential and shall be open to public inspection or disclosure only to the extent required by State or federal law. DPSS, DA, and/or CDHCS Investigators may disclose information from the record to any official conducting an investigation, prosecution, or civil proceeding in connection with administration of the IHSS program to the extent necessary.

## VI. IHSS OVERPAYMENTS/UNDERPAYMENTS ACTIVITIES AND DATA

Quality Assurance Reviews

The IHSS Quality Assurance/Quality Improvement (QA/QI) program was implemented in December 2005 and Los Angeles County began conducting IHSS QA reviews in January 2006. During this period, Los Angeles County did not capture and report dollar amounts associated with those cases identified as having actual under/overpayments.

Los Angeles County has a dedicated IHSS QA/QI unit, consisting of one Social Services Supervisor and six allocated Social Workers whose full-time job is performance of the IHSS QA activities. Currently, Los Angeles County DPSS conducts quarterly QA/QI monitoring reviews on IHSS cases selected at random from all IHSS district offices and all Social Workers involved in the assessment process. In the monitoring process, each of the full-time IHSS QA Social Workers is required to complete at least 250 desk reviews and conduct home visits for a sub-sample of 50 cases each fiscal year. This represents a small sampling of the Los Angeles County IHSS caseload.

Enhanced QA/QI Program

An additional unit will allow an expanded sample of IHSS cases each quarter and additional focused reviews in support of program integrity and fraud detection. The unit will consist of five SWs, and a Supervisor. This unit will identify potential overpayments/underpayments and also identify training needs and error trends.

Based on these results, the Department will develop training material on fraud prevention techniques and best practices.

- The Review Process

  The QA/QI reviews cover the following IHSS programs as mandated by the State: Personal Care Services Program (PCSP), IHSS Plus Waiver (IPW) and IHSS Residual (IHSS-R). The reviews cover key areas of assessment and include full case reviews, focused reviews and home visits, leading to corrective

action and the need to monitor for overpayments, underpayments and other actions, as appropriate.

Full Case Reviews are conducted to verify that Social Workers applied appropriate actions in the following areas: timely application processing, eligibility determination, needs assessment, provider payroll process, and civil rights compliance.

Focused Reviews are conducted to verify that SWs applied appropriate actions for timely application processing, eligibility determination and needs assessment, and to verify appropriate actions in a specific service area, e.g., Protective Services, Paramedical, Civil Rights Compliance, Provider Payroll, etc.

Data Match Reviews are conducted to ensure that duplicate payments are not issued for identical services or for services that supplant the services provided by supportive services programs. Two examples of data match reports are the Provider 300+ Paid Hours and the Death Match Report.

- The Provider 300+ Paid Hours Report consists of providers who have worked 300 or more hours per month for one or more consumers. These cases are reviewed by Social Workers to ensure quality services are provided to the consumer and the consumer's safety.

- The Death Match Report is issued quarterly by the State Controller's Office and matched to the consumers'/providers' Social Security Number and the number of payments, and amount paid/made after the reported date of death.

The above noted focused reports are distributed to IHSS district offices to confirm the hours worked and the benefits rendered. QA re-reviews the matches to determine that appropriate actions have been taken. If errors are identified in the re-review, districts are requested to take corrective action, including initiating fraud referrals, and confirm to QA staff with supporting documentation within the established timeframe.

- IHSS QA Review Data Collection

  *Part 1 - Pre-Review and Preliminary Case Assessment*

  - Conduct Entrance Conference with district managers and liaisons to explain scope, methodology and timeline of review.
  - Reconcile sample case listing and confirm availability of physical case files.
  - Access CMIPS and MEDS to validate sample case/consumer data.

*Part 2 - Physical Case Desk Review*

- Validate appropriate application of State/federal regulations using the Manual of Policy and Procedures and review tools specific to the designated type of review.
- Reviewer verifies the following and documents inconsistencies on the review tool:

  -- Timeliness of IHSS application processing, and physical application;
  -- Approved case - last face-to-face meeting with consumer conducted within the last 12 months;
  -- Terminated/Denied case – Social Worker appropriately documented reason(s) for termination/denial and input correct termination/denial code in CMIPS;
  -- Timely issuance of Notice of Action (NOA) to consumer and filed in case folder;
  -- Applicable State/County forms on file and complete;
  -- Data on County budget worksheet matches data input on State forms; and
  -- Case documentation for entire case review covers five review areas and actions are justified.

*Part 3 - Home Visits*

- For a sub-sample of desk review cases, home visits are conducted to validate information in case files with the results reported on the QA Home Visit Questionnaire.
- Discovered inconsistencies are reported to the districts with a request to follow up and conduct a subsequent home call or phone call to the consumer or provider.
- Districts are further requested to take immediate action, including initiating fraud referrals, and to provide QA staff with a report of completed corrective action, including supporting documentation, within the established timeframe.
- QA staff controls for verification of necessary action.

*Part 4 - Reporting QA Findings*

As the QA reviewers annotate procedural errors and inconsistencies directly on the review tool, the review tool serves to: inform district management of the review findings, identify all items that require corrective action, request a corrective action response, and reflect the response due date.

*Underpayments/Overpayments*

The QA review tool indicates inconsistencies which identify potential underpayments/overpayments that are subsequently reported to district management with a request to closely evaluate these findings, validate the cause of identified underpayments/overpayments, submit a corrective action response with supporting documentation, including fraud referrals, as appropriate, and confirm completion to QA staff within the established timeframe. Causes for underpayments/overpayments may be: 1) a time gap in the date of IHSS consumer eligibility and services rendered and the effective date of services input on CMIPS, 2) agency errors such as incorrect computations in service hours or functional index values.

*Potential Fraudulent Activities and Fraud Indicators*

The subject activities/indicators include the following: consumer falsifies severity of disability to obtain services with higher service hours; consumer and provider collusion and misuse of IHSS funds; provider submits timesheets and claims payment while consumer is hospitalized, institutionalized, out of town, incarcerated and/or whereabouts are unknown, and provider submits timesheets and claims payment after the consumer's death. District management is requested to closely evaluate these findings, validate the cause of potentially fraudulent activities and submit a corrective action response, including supporting documentation, and confirm completion to QA staff within the established timeframe.

*Part 5 – QA Follow-Up*

Upon receipt of all corrective action responses from each district, the QA Unit Monitors will flag any outstanding issues, and follow-up, as needed, according to the established review timeline.

- **Benefit Recovery**

DPSS, the DA and CDHCS will coordinate IHSS benefit recovery efforts. Los Angeles County takes all steps necessary to recoup or recover from the consumer or provider funds paid to the IHSS provider when the consumer was not eligible for the level of benefits paid.

**Consumer Overpayments**

There are three types of overpayments:

- **Consumer/Provider Error** - The consumer or provider reported incorrect information or failed to report information;

- **Administrative Error** - Overpayment results from agency or system error. The agency commits an error or the system calculates an authorization for more than the consumer was entitled; and

- **Intentional Program Violation** - The consumer or provider willfully reported information or failed to report information in order to receive more benefits.

Designated staff shall recover an overpayment from the consumer when he/she receives benefits for which he/she was not eligible such as:

- The authorized amount of IHSS services would have been less due to inaccurate reporting of income. The excess amount paid is considered as an overpayment;

- The consumer was absent from the State/County and services claimed were not provided;

- There would not have been eligibility if income, resources and/or the need for IHSS services had been accurately reported;

- A change in income, resources, and the need for IHSS services and/or household composition was not reported within 10 days of the change and the change would have resulted in a lesser benefit received; and

- When the Social Worker did not act upon reported information or entered incorrect information into the CMIPS system that resulted in an eligibility related overpayment.

**Provider Overpayments**

Designated staff shall recover an overpayment from a Provider when:

- Provider received payment for services they did not provide and/or operating outside of regulations;

- Provider recorded incorrect hours of service which caused an overpayment;

- When the Social Worker entered incorrect authorization or provider information or failed to act on reported information resulting in an authorization related overpayment; and

- The Provider did not report when a customer stopped using their services.

**Establishing Overpayment Claims for Providers**

DPSS must make efforts to establish overpayment claims within 30 days of discovery of the overpayment. DPSS must complete and mail to the Provider a worksheet showing how the amount of the overpayment was calculated.

**Recovery of Consumer Overpayments**

Recovery of consumer overpayments requires a payment agreement. All consumers for whom an overpayment has been calculated are required to complete and sign a repayment agreement. Once the repayment agreement has been completed, CDHCS will send the consumer a benefit recovery notice.

In the event of unsuccessful collection efforts and after the third notice, CDHCS will begin centralized collection efforts. Tax intercept may be used to obtain repayment. Claims may also be collected through the use of the Department of Revenue (DOR) Tax Offset Program.

**Recovery from Providers**

All overpayments made to Providers due to fraud or administrative error must be collected. For situations where a Provider provides services, and it is later discovered that the consumer was not eligible or entitled to that service, the Provider may not be penalized for giving care in good faith. The ineligible consumer is responsible for the overpayment.

For all Providers, overpayments are recorded by entering the amount of the negative adjustment in CMIPS for the specific authorizations and weeks for which the overpayment took place.

Recovery will occur in one of the following ways depending on the Provider's status:

- If the Provider is active and has a current authorization that they are receiving payment for, CMIPS will deduct a specific amount from the Provider's future payments until the negative adjustment has been satisfied; and

- If the Provider is not active and/or is not receiving payments, the negative adjustment will be automatically referred to the benefit recovery section and the repayment agreement process will begin.

We are confident that by implementing these collective strategies we will not only mitigate fraud but also reduce the occurrence of overpayments and underpayments. Our targeted focus during the initial application process, in tandem with the implementation of new provider requirements aimed at reducing fraud, will not only deter but also identify fraud early in the process rather than later.

## VII. PROPOSED BUDGET FOR UTILIZATION OF FUNDS

The costs associated with the IHSS program integrity enhancements incorporated in this plan are within the budgeted amount appropriated to Los Angeles County as part of the State's Budget Act of 2009, and as outlined in the September 25, 2009 letter to all County Board of Supervisors, for the purposes of fraud prevention, detection referral, investigation, and additional program integrity efforts related to IHSS. Our total estimated annual costs to implement these initiatives are $9,460,000. These costs will be prorated based on plan approval and allocation of funds.

## VIII. ANNUAL OUTCOMES REPORT

Los Angeles County DPSS will provide an annual outcomes report by August 1 of each year, identifying activities, data and outcomes associated with the County's efforts to mitigate, prevent, detect, investigate and prosecute IHSS fraud during the previous fiscal year in a format to be provided by CDSS.

## IX. TRACKING/REPORTING IHSS FRAUD DATA AND ACTIVITIES

Los Angeles County DPSS will develop a system to track and report outcomes of its efforts to CDSS. We will track data on overpayments/underpayments, the number of fraud referrals, and their outcomes and utilization of the District Attorney in combating IHSS fraud. SFY 2009-10 data will be provided by August 1, 2010 in the required format designated by CDSS. (See Enclosure D)

In addition, Los Angeles County DPSS will submit the required Plan on June 1, 2010, and each subsequent year, which includes updates to the previous year's Plan, as well as an agreement to continue tracking, reporting, and submitting final data for the previous fiscal year to CDSS by August 1.